



March 11, 2009

Members of the Insurance and Real Estate Committee  
Connecticut General Assembly  
Legislative Office Building  
Room 2800  
Hartford, CT 06106

Re: SB 958, *An Act Concerning Utilization Review*

Dear Committee Members:

I write this letter to respond to the testimony submitted by the Insurance Department (CID), Anthem and the Connecticut Association of Health Plans on the above-captioned bill. I know it is difficult for you to make decisions about these matters without relying on the testimony of others, so it makes the task of weighing the importance of a bill even more difficult if some of that testimony is unreliable. My intent then is to clarify mischaracterizations of the legislation and the unsubstantiated generalizations about the need for and impact of the bill by detractors of SB 958.

The Office of the Healthcare Advocate is the only state agency that is dedicated exclusively to advocating for consumers in health insurance matters. This is significant because representations we make in our testimony, or with our submission of bills, are based directly on the experience of the many consumers we serve. Second, of the entities that testified on this bill, our office is the only office—in addition to some advocacy provided by the Attorney General's office—that actually assists and walks with the consumer through the utilization review process on a daily basis. We take cases all the way through the process, so our proposal to revise the utilization review and appeal processes is based on sound experience and judgment. Third, the revisions we've suggested are consistent and on par with principles of fairness that should be in place when a consumer is challenging a much more sophisticated insurance company on the provisions of a complicated insurance contract concerning such a critical matter as healthcare. We must level the playing field. Fourth, this is the third year in a row we proposed this bill. If we thought the utilization process had reached a level of acceptable fairness, we would not have proposed this bill again. This is not something the managed care organizations are willing to do on their own. This should be the year of its passage.

The following are examples of statements made in testimony given in opposition to the bill. I respectfully suggest that these statements are intended to provoke unjustified fears of a tidal wave of appeals. Any claim that a change in the process will create a huge influx of appeal activity is not based on a review of the facts. Though it would be wonderful if there were a double-digit increase in the current 4% of patients who appeal utilization review denials, this is an unlikely possibility. With approximately 17% of utilization reviews denied outright, the process has to change. After all, what we are talking about is allowing consumers to enforce their rights to contractually promised services.

The Insurance Department raises several concerns with the bill, some of which are based on a misreading of the bill, and others, such as the one below, which are conclusory and seemed designed to stop the bill without providing explanation.

The Department also believes the hearing process, while well-intentioned, raises a host of issues, including: (1) privacy issues, (2) ownership issues, (3) who may access the data, (4) how long must the data be maintained, and, (5) who bears what costs. , etc.

It's interesting that the Department raises privacy issues. The current grievance process involves the participation of the same parties that our revised appeal process would allow. There are no privacy issues that are not already addressed in current law. As for the rest of the list of concerns, it is hard to respond to such general statements without further explanation of what the Department means. Again, as a party that never attends or participates in the utilization review process, the Department's statements are based on generalizations about how the current process works.

Anthem and the Association of Health Plans make similar exaggerated references to the bill's increasing health cost while doing nothing to improve the process. I understand that they have a standard reaction to any bill designed to improve consumer access to healthcare services; "it will only increase costs and do nothing to help consumers". I ask that you seriously consider the source when reviewing their comments. It is difficult to believe that a meaningful appeals process will increase costs, since the determinations that are appealed are directly related to contracted services.

The Association of Health Plans cites the external review process as justification for failing to improve the earlier portion of the utilization review process. This is unsupportable. The high rate of reversals on external appeal documented in the managed care report card only reinforce the fact that the process needs to be improved from the beginning. The external review takes place only after the internal appeals are exhausted and takes a considerable length of time. While I welcome improvements to the external review process, those improvements are no substitute for a better internal appeals process.

Finally, the Department and the insurers make some general statements about the inclusion of retrospective determinations of medical necessity. I'd like to clarify that the current utilization review law contains a substantial flaw in its exclusion of

retroactive determinations of medical necessity. Contrary to our opposition's statements, SB 958 would do nothing to add substantial costs to the system or require the licensing of new utilization review companies. The fact is that many medical necessity determinations are made only when a claim is submitted – not all services require prior authorization or concurrent determinations of medical necessity for coverage. Services are often denied on the basis of medical necessity when the claim is adjudicated. There is no adequate remedy for consumers in this circumstance. Many of the entities that process claims also conduct utilization review, and in the case of Anthem, the largest utilization review company and insurer in the state, it is no excuse to argue that it is cost prohibitive to provide a meaningful route for a consumer to challenge a claim based on a denial of medical necessity.

Anthem states that it believes SB 958 changes the definition of medical necessity that this office and the Attorney General's office worked so hard to codify. Anthem's assertion is patently false. Our bill clarifies that company-specific, medical criteria are solely guidelines and do not carry the full force of law that many utilization review companies continue to assert. It is the medical necessity definition that governs decisions.

Under our bill, utilization review companies will have to provide the kind of fair appeal process that guarantees consumers are given every chance to prove their case. Utilization review companies that can no longer rely on checklists to deny coverage for medically necessary care. Under the current process, the consumer has little chance of success without assistance.

Sincerely,

A handwritten signature in blue ink that reads "K. Lembo" with a horizontal line extending to the right.

Kevin Lembo  
State Healthcare Advocate

cc: Members of the Insurance and Real Estate Committee  
Victoria Veltri, General Counsel